MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08892

CERTIFICATE OF DEATH

Reg. Dist. No. 08903 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harrisburg 75 x 3
d. STREET ADDRESS: 252 Liberty Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ippolito — Middle — Last: Alitto

4. DATE OF DEATH: Month: Aug. — Day: 27 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 14, 1872

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months: 0 — Days: 13
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Storekeeper

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Castiglione Cosentingo

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Salvatore Alito

14. MOTHER'S MAIDEN NAME: Marie Barbuslio

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: Agustalitto Alitto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-25, 19 57, to 8-27, 19 57, that I last saw the deceased alive on 8-27-57, 19 , and that death occurred at 6 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L Ew Deltz M.D. — ADDRESS (Street, city or town, state): L Ew Deltz — DATE SIGNED: 8-29-57

PHYSICIAN'S NAME (Type): Hagerstown Md — Hagerstown Md — 8-29-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-30-1957

22c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cem.

22d. LOCATION (City, town, or county) (State): Harrisburg, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: P. Franklin Ponzer — ADDRESS: Hagerstown Maryland

24a. REC'D BY REGISTRAR: Aug 29, 1957

24b. REGISTRAR'S SIGNATURE: Chas H Boswell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08893 08904

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: -
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Emergency Room - Hopsital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville 15262
d. STREET ADDRESS: 1108 Old Dover Way
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Carleton — Last: Baer

4. DATE OF DEATH: Month: August — Day: 8 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 4,1924

9. AGE (In years last birthday): 33 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Nat'l Cash Register

11. BIRTHPLACE (State or foreign country): Penna

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Donnie T. Baer

14. MOTHER'S MAIDEN NAME: Kathryn Rae Baer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 191-18-9599

17. INFORMANT: Joseph R. Baer- Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carbon- Monoxide Poisoning — INTERVAL BETWEEN ONSET AND DEATH

973.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Connected hose from exhaust into automobile

20c. TIME OF INJURY: Hour: 3:00 a. m. — Month, Day, Year: Aug. 8 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (State): Rural- Hagerstown Wash Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: August 8 '57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/10/57

22c. NAME OF CEMETERY OR CREMATORY: Uniontown Cemetery

22d. LOCATION (City, town, or county) (State): Uniontown Fayette Co Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR: Aug. 12. 1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08905

08942

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 7½ yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: Hotel
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: NANCY Middle: Lost: Boyle

4. DATE OF DEATH: Month: August Day: 28, Year: 1957

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 24, 1870

9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months: 5 Days: 3 IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Williamsport, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: James William Findlay

14. MOTHER'S MAIDEN NAME: Roberta C. Arter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Nancy Knowles — Address: 200 E. 66th St. N.Y.C. N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

331X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 5, 1954 to Aug 28, 1957, that I last saw the deceased alive on Aug. 27, 1957, and that death occurred at 12:35 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Hook M.D. ADDRESS (Street, city or town, state): 28 W. Potomac Street DATE SIGNED: 29 Aug 57

PHYSICIAN'S NAME (Type): PAUL HOOK, M.D. Williamsport, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 29-57

22c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

22d. LOCATION (City, town, or county): Williamsport (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Leaf ADDRESS: Williamsport, Md

24a. REC'D BY REGISTRAR DATE: Aug. 29 57

24b. REGISTRAR'S SIGNATURE: E Lee McElroy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08943 **CERTIFICATE OF DEATH** Reg. Dist. No. 08906 8.61

1. PLACE OF DEATH
a. COUNTY: Washington Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 11 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro. 75 X-3
d. STREET ADDRESS: 119 West 3rd St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Benjamin Middle Franklin Last Burger

4. DATE OF DEATH: Month August Day 31 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: March 9, 1872

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Penna R.R.

10b. KIND OF BUSINESS OR INDUSTRY: ASSISTANT MANG. FREIGHT OFFICE.

11. BIRTHPLACE (State or foreign country): Quincy, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gideon Burger

14. MOTHER'S MAIDEN NAME: Lavina ~~Hemlinger~~ MANGES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (Address): Paul W. Burger — 119 W. 3rd St, Waynesboro, Pa.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO (b): Arteriosclerotic Heart Disease — 6 months
DUE TO (c):
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 27, 1957, to Aug. 31, 1957, that I last saw the deceased alive on Aug 31, 1957, and that death occurred at 7:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Haak M.D. ADDRESS (Street, city or town, state): 28 W. Potomac St. DATE SIGNED: 31 Aug 57

PHYSICIAN'S NAME (Type): PAUL HAAK M.D. Williamsport, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/4/1957

22c. NAME OF CEMETERY OR CREMATORY: PRICE'S CEMETERY

22d. LOCATION (City, town, or county) (State): WAYNESBORO R.D. 2, Pa

23. FUNERAL DIRECTOR'S SIGNATURE: Walter G. Hare ADDRESS: Waynesboro, Pa.

24a. REC'D BY REGISTRAR DATE: Sept. 4 1957

24b. REGISTRAR'S SIGNATURE: C Lee McElroy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08894 — 08907 — Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): at home 128 S. Potomac Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 128 S. Potomac Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry — Middle: Augustus — Last: Burger
4. DATE OF DEATH: Month: Aug. — Day: 29 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 18, 1884
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Office Worker
10b. KIND OF BUSINESS OR INDUSTRY: Secretary Woodmen of World
11. BIRTHPLACE (State or foreign country): Hagerstown
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Augustus Burger
14. MOTHER'S MAIDEN NAME: Mrs. Henrietta Rider

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 214-09-7188
17. INFORMANT — Address: Mrs. Anna B. Burger, 128 S. Potomac St City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH: none
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none
20c. TIME OF INJURY — Hour: o. m. p. m. none — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none
20f. (City or town) — (County) — (State): - - -

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Aug. 30 '57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-3-57
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Wash., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. T. Norment
ADDRESS: Hagerstown, Maryland
24a. REC'D BY REGISTRAR (DATE): Sept. 3, 1957
24b. REGISTRAR'S SIGNATURE: Blanche Bowers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C8895 08908

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 hr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): On Key St.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore (28) 0352.2
d. STREET ADDRESS: 401 Overbrook Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT — Middle JACOB — Last CANFIELD
4. DATE OF DEATH: Month August — Day 13 — Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jany 18 1918
9. AGE (In years last birthday): 39 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Glenn Martin Co
11. BIRTHPLACE (State or foreign country): Montanna Butte Silver Bow
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Robert W. Canfield
14. MOTHER'S MAIDEN NAME: Florence Hiatt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.2
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs Lili Canfield 401 Overbrook Rd Baltimore Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a):
DUE TO (b): Gun shot wound thru heart, hemorrhage & shock
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 976X
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): shot self thru heart with 22 calibre revolver
20c. TIME OF INJURY: Hour 8 a.m. p.m. — Month, Day, Year 8-13 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town): Hagerstown — (County): Wash. — (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Aug 14-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/14/57
22c. NAME OF CEMETERY OR CREMATORY: Deposit Cemetery
22d. LOCATION (City, town, or county) (State): Deposit Broome Co New York

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR — DATE: Aug. 16 1957
24b. REGISTRAR'S SIGNATURE: B Brady Rogers

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08944 Item 3 Film C22] 10-16-57 et

CERTIFICATE OF DEATH

08909

Reg. Dist. No. 30-1

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, RB
c. LENGTH OF STAY IN 1b life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION " "

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X27 Hagerstown
d. STREET ADDRESS R#3 Hagerstown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Twin I Middle: not named Last: Chaney

4. DATE OF DEATH Month: aug. Day: 20 Year: 1957

5. SEX M/F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 8-20-57

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months 5 Days 14
IF UNDER 24 HRS.: Hours 3 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Harry Chaney

14. MOTHER'S MAIDEN NAME Christina Staley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity 5½ MO
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH 2 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 57, 19__, to Aug 57, 19__, that I last saw the deceased alive on Aug 57, 19__, and that death occurred at 7P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Ralph E. Young M.D. ADDRESS (Street, city or town, state) Williamsport, Md DATE SIGNED 8-23-57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) V

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

24a. REC'D BY REGISTRAR DATE 9/3/57

24b. REGISTRAR'S SIGNATURE Chas Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1100330 x V0

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08896 Item 3& Block 22 FilmG221 10-16-57 et

CERTIFICATE OF DEATH

08910 302 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.R. #3 Hagerstown
d. STREET ADDRESS 1 King St e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Twin II Middle Doris marie Last Chaney
4. DATE OF DEATH Month Aug. Day 21 Year 1957
5. SEX F
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8-21-57
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Harry Chaney
14. MOTHER'S MAIDEN NAME Christina Staley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 774X Premature DUE TO 5½ Mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 6 HRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/20/57, 19, to 8/21/57, 19, that I last saw the deceased alive on 8/21/57, 19, and that death occurred at 11:30 A.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Ralph L. Young M.D. ADDRESS (Street, city or town, state) William Street Hagerstown Md DATE SIGNED 8/23/57
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF ?
22c. NAME OF CEMETERY OR CREMATORY Hospital disposal
22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
24a. REC'D BY REGISTRAR DATE 9/3/57
24b. REGISTRAR'S SIGNATURE Chas. Downey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08897

CERTIFICATE OF DEATH

08911

Reg. Dist. No. 302

1

M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Dist. of Columbia — b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Maryland c. LENGTH OF STAY IN 1b: 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D. C. 47x-3 ✓
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital	d. STREET ADDRESS: 1815 17 ths St. N. W. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
EDNA	ALICE	COLLIER	Aug.	26	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White		Sept. 1 1914	42 yrs.	11	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Court Reporter	U.S. Gov. Dept. Of Labor	Stoneham Mass.	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Collier	Ada Rose Brock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No / No	217 10 3040	Mrs. James Sachs Funkstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

490 x

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Circulatory failure (shock) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/24, 1957, to 8/26, 1957, that I last saw the deceased alive on 8/26 1957, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Hornbaker M.D. — ADDRESS (Street, city or town, state): 154 West Washington St., — DATE SIGNED: 8:28:57

PHYSICIAN'S NAME (Type): John H. Hornbaker, M.D. — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Aug. 30-57	Riverview Cemetery	Williamsport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Albert L Leaf Williamsport, Md	Aug. 30, 1957	Thad Bowers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08898

CERTIFICATE OF DEATH

08912

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Penna. — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greencastle, Pa. 75 x - 3
d. STREET ADDRESS: 18 N. Carlisle St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HELEN Middle M. Last COLLIER
4. DATE OF DEATH: Month August Day 31 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV. 30, 1873
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical Worker
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
11. BIRTHPLACE (State or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Col. Geo. W. Collier
14. MOTHER'S MAIDEN NAME: Ann Elizabeth Michael

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Miss Dail Hemminger — Address: 37 W. Madison, Greencastle, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asteria - Selerotic Heart Dis — INTERVAL BETWEEN ONSET AND DEATH
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): a Congestive Failure — Few
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 17 Aug, 1957 to 30 Aug, 1957, that I last saw the deceased alive on 30 Aug, 1957, and that death occurred at 3:00 A.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Greencastle, Pa. — DATE SIGNED
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/3/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
22d. LOCATION (City, town, or county) (State): Greencastle, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: W. E. Minnich — ADDRESS: Greencastle, Pa
24a. REC'D BY REGISTRAR DATE: Aug. 31, 1957
24b. REGISTRAR'S SIGNATURE: Ethel T. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08899 **CERTIFICATE OF DEATH** 08913 302 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Sharpsburg Maryland RFD
d. STREET ADDRESS: 1 Antietam
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gilbert — Middle: R — Last: Crampton

4. DATE OF DEATH: Month: Aug. — Day: 13 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 9 1910

9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months: 11 — Days: 3
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Assembly
10b. KIND OF BUSINESS OR INDUSTRY: Aircraft Fairchilds

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Harvey Crampton

14. MOTHER'S MAIDEN NAME: Grace Viola Boyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-10-3587

17. INFORMANT: Mrs. Hattie Crampton — Address: Antietam Sharpsburg Md RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage
DUE TO
(b): Cause unknown.
DUE TO
(c):

Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse last.

331x

INTERVAL BETWEEN ONSET AND DEATH: 26 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/12/57, 19____, to 8/13/57, 19____, that I last saw the deceased alive on 8/12/57, 19____ and that death occurred at 3:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter H. Shealy M.D.
ADDRESS (Street, city or town, state): Sharpsburg, Md.
DATE SIGNED: 8/14/57.

PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 15-57
22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
22d. LOCATION (City, town, or county) (State): Sharpsburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Albert Leaf — ADDRESS: Williamsport, Maryland
24a. REC'D BY REGISTRAR: Aug. 17 1957
24b. REGISTRAR'S SIGNATURE: Chas H Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08990

CERTIFICATE OF DEATH

08914

Reg. Dist. No. 301

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 318 South Potomac Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gregory — Middle: Allen — Last: Delouney

4. DATE OF DEATH: Month: August — Day: 20 — Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: August 16, 1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days: 4
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Delouney

14. MOTHER'S MAIDEN NAME: Betty Jane Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mr. Charles Delouney — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hilar Membrane Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Prematurity

774X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

21. I certify that I attended the deceased from 8/16/57, 19____, to 8/20/57, 19____, that I last saw the deceased alive on 8/20/57, 19____, and that death occurred at 5 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl Young M.D. — ADDRESS (Street, city or town, state): Hagerstown, Md — DATE SIGNED: 8/21/57

PHYSICIAN'S NAME (Type): SEARL YOUNG M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/21/1957

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — R. Franklin Rouzer — ADDRESS: Hagerstown, Maryland

24a. REC'D BY REGISTRAR: Aug. 24.1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/SS

2281254XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08945

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08915

Reg. Dist. No. 301

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 7 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 129 E. Potomac Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport Md. RFD X/
d. STREET ADDRESS: Hopewell Road /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Mr. Benjamin; Middle: Roy; Last: Dewey

4. DATE OF DEATH: Month: Aug.; Day: 26; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: June 28 1892

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: 2; Days: 1
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tenant Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Quincy Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Lum Dewey

14. MOTHER'S MAIDEN NAME: Susan Harshman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-30 9939

17. INFORMANT: Mrs. Frances Dewey
Address: Hopewell Road Williamsport Md RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1
DUE TO (b): Acute Coronary occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour o. m. p. m. None Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: S. Robert Wells M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: Aug. 27 '57

EXAMINER'S NAME (Type): S. Robert Wells

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 29-57
22c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery
22d. LOCATION (City, town, or county) (State): Williamsport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Albert Leigh
ADDRESS: Williamsport Md

24a. REC'D BY REGISTRAR DATE: Aug 27-57

24b. REGISTRAR'S SIGNATURE: E Lee McElroy

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08971

CERTIFICATE OF DEATH

08916

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna
b. COUNTY: Fulton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Amaranth 75x-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Dwane Middle: Derrick Last: Diehl

4. DATE OF DEATH: Month: August Day: 2 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 5/30/57

9. AGE (In years last birthday): ____ yrs.
IF UNDER 1 YEAR: Months: 2 Days: 3
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Berkeley Springs W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Allen Crown Diehl

14. MOTHER'S MAIDEN NAME: Frances Catherine Munson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Allen C. Diehl — Address: Amaranth Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Congenital Heart Disease (Transposition of the — 2 mos.
DUE TO (c): great vessels.

754.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/26, 1957, to 8/2, 1957, that I last saw the deceased alive on 8/1, 1957, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard A. Young M.D. ADDRESS (Street, city or town, state): 302 N. Potomac St. DATE SIGNED: 8/2/57

PHYSICIAN'S NAME (Type): Richard A. Young Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL: (Specify) Burial

22b. DATE THEREOF: Aug 4 1957

22c. NAME OF CEMETERY OR CREMATORY: Whips Cove Cem

22d. LOCATION (City, town, or county) (State): Amaranth Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: J. M. Sipes ADDRESS: Harrisonville Pa

24a. REC'D BY REGISTRAR DATE: Aug 5, 1957

24b. REGISTRAR'S SIGNATURE: Edward H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08902 — Reg. Dist. No. 08917 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: MINUTES
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: WASH.CO.HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 ROHRERSVILLE
d. STREET ADDRESS: 1 MAIN STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

DR. KNEISLEY 148 W. WASH-ST HAGERSTOWN MD. 81

3. NAME OF DECEASED (Type or print): First ADA — Middle M — Last EASTON
4. DATE OF DEATH: Month AUGUST — Day 15 — Year 1957

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JUNE 7 1884
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): ROHRERSVILLE WASH.CO.MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: MILLARD CLOPPER
14. MOTHER'S MAIDEN NAME: SUSAN HUFFER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service) NONE
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT — Address: MISS GLADYS EASTON ROHRERSVILLE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary edema	7 hr.
DUE TO		
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerotic heart disease	10 yr.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus 260X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 19 50 to Aug. 15 19 57 that I last saw the deceased alive on July 20 1957, and that death occurred at 9:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: B B Kneisley M.D. — ADDRESS (Street, city or town, state): 148 West Washington St. — DATE SIGNED: 8/16/57

PHYSICIAN'S NAME (Type): B. B. Kneisley, M .D. — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: AUG.17 1957
22c. NAME OF CEMETERY OR CREMATORY: ROHRERSVILLE CEMETERY
22d. LOCATION (City, town, or county) (State): ROHRERSVILLE WASH.CO.MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Bast-Tuml Home — ADDRESS: Boonsboro Md.
24a. REC'D BY REGISTRAR DATE: Aug 22 1957
24b. REGISTRAR'S SIGNATURE: Richard H Boerner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08918

Dr J. H. Kehne

08903

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 7 Weeks
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Wash. County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 107 Clinton Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DELLA Middle MAE Last EMMERT

4. DATE OF DEATH: Month August Day 3 Year 1957

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 7 1891

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sewing
10b. KIND OF BUSINESS OR INDUSTRY: Beachley-Reichard Co
11. BIRTHPLACE (State or foreign country): Fairplay Wash. Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Emmert

14. MOTHER'S MAIDEN NAME: Ida Sheeley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 214-09-9513

17. INFORMANT: Mrs Mary E. Renner
Address: 107 Clinton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hagerstown Md ACUTE INTESTINAL OBSTRUCTION — INTERVAL BETWEEN ONSET AND DEATH: 8 WEEKS

153X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ADENOCARCINOMA LEFT COLON RECURRENT — 2½ YEARS

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ____ o. m. p. m. Month ____ Day ____ Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JUNE 16, 1957, to AUGUST 2, 1957, that I last saw the deceased alive on AUGUST 2, 1957, and that death occurred at 10:08AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Kehne M.D.
ADDRESS (Street, city or town, state): 131 W. WASHINGTON ST.
DATE SIGNED: 8/3/57

PHYSICIAN'S NAME (Type): JOHN H. KEHNE M.D.
HAGERSTOWN, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/4/57
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR: Aug. 6, 1957
24b. REGISTRAR'S SIGNATURE: Ethel T. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08946

CERTIFICATE OF DEATH

08917
Reg. Dist. No. 207

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
c. LENGTH OF STAY IN 1b: 2 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: FAHRNEY-KEEDY MEM. HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO X2
d. STREET ADDRESS: FAHRNEY-KEEDY MEM. HOME
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First DANIEL — Middle E. — Last ENGLER

4. DATE OF DEATH: Month AUG. — Day 18 — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAR 13 - 1875

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINISTER - BRETHREN CHURCH

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: SOLOMON P. ENGLER

14. MOTHER'S MAIDEN NAME: MARY ROOP

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT (Address): MARIANNA ENGLER - F.K. MEM. HOME BOONSBORO, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Haemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs
331x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 18, 1957 to August 18, 1957 that I last saw the deceased alive on August 18, 1957, and that death occurred at 6 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: G. W. LeVan M.D. ADDRESS (Street, city or town, state): Boonsboro DATE SIGNED: 8/18/57

PHYSICIAN'S NAME (Type): G. W. LeVan Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/21/57

22c. NAME OF CEMETERY OR CREMATORY: PIPE CREEK CEM

22d. LOCATION (City, town, or county) (State): CARROLL COUNTY, MD

23. FUNERAL DIRECTOR'S SIGNATURE: D. D. Hartzler & Sons, New Windsor, Md. ADDRESS

24a. REC'D BY REGISTRAR DATE: AUG 22 1957

24b. REGISTRAR'S SIGNATURE: J. H. Bastg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08994

CERTIFICATE OF DEATH

08920

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital
d. STREET ADDRESS: 219 Colonial Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SAMUEL — Middle CRAWFORD — Last ESTERLINE

4. DATE OF DEATH: Month August — Day 30 — Year 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: November 26, 1875

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months 9 — Days 4
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Conductor

10b. KIND OF BUSINESS OR INDUSTRY: Pennsylvania R.R.

11. BIRTHPLACE (State or foreign country): Anderson, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Esterline

14. MOTHER'S MAIDEN NAME: Annie Crawford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT — Address: Mrs. Jane Etchison — Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sarcoma of the lung with metastasis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
163X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 15, 1957 to Aug. 30, 1957, that I last saw the deceased alive on Aug. 30, 1957, and that death occurred at 12:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: B. B. Kneisley M.D. — ADDRESS (Street, city or town, state): 148 West Washington Street — DATE SIGNED: 8/30/57

PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D. — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/2/1957

22c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery

22d. LOCATION (City, town, or county) (State): Altoona, Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — R. Franklin Rouzer — ADDRESS: Hagerstown, Md.

24c. RECEIVED BY REGISTRAR — DATE: Sept. 5, 1957

24b. REGISTRAR'S SIGNATURE: Edith H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08905

CERTIFICATE OF DEATH

08921

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 37 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 128 Ross St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Charles — Middle Edward — Last Fair

4. DATE OF DEATH: Month August — Day 25, — Year 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 26, 1892

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): maintenance

10b. KIND OF BUSINESS OR INDUSTRY: city government

11. BIRTHPLACE (State or foreign country): Taneytown, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel Fair

14. MOTHER'S MAIDEN NAME: Sarah Schriver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-2449

17. INFORMANT — Address: Mary L. Fair, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 year
581.0
DUE TO (b): Hypertension Vascular Lesions — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-30-57, 19____, to 8-25-57, 1957, that I last saw the deceased alive on 8-24-57, 19____, and that death occurred at 5 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr W Dutto M.D. — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: 8/26/57

PHYSICIAN'S NAME (Type): Dr W Dutto Jr — Hagerstown Md — 8/26/57

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 8-27-57

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: Aug. 29. 1957

24b. REGISTRAR'S SIGNATURE: Elizabeth Boucher

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08906

CERTIFICATE OF DEATH

08922

Reg. Dist. No. 302

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown c. LENGTH OF STAY IN 1b: 4 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 444 West Franklin St	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 03 d. STREET ADDRESS: 444 West Franklin St e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First ANNIE — Middle ELIZABETH — Last FOX	4. DATE OF DEATH: Month August — Day 20 — Year 1957
5. SEX: Female	6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: Sept 7 1867
9. AGE (In years last birthday): 89 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Md. Clear Spring Wash. Co	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Werdebaugh	14. MOTHER'S MAIDEN NAME: Rosanne Whetstone
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ———	16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Alpha Grove — Address: 444 W. Franklin st	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — Hagerstown Md,

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 422.1 — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cerbral Hemorrhage — 6 days

DUE TO (c): Cardio Vascular Renal — 15 Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-15-, 1957, to 8-20-, 1957, that I last saw the deceased alive on 8-19-57, 19——, and that death occurred at 2 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr EW Dietz M.D. — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: Aug 24 57

PHYSICIAN'S NAME (Type): DREW DIETZ JR — Hagerstown Md — Aug 24 57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 8/23/57	22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: Aug 24 1957

24b. REGISTRAR'S SIGNATURE: Chas H Boevers

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08923

08957

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 23 Hagerstown
d. STREET ADDRESS: 238 Jefferson Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Danny — Middle: — Last: Fratianni

4. DATE OF DEATH: Month: August — Day: 1 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 19, 1934

9. AGE (In years last birthday): 23 yrs.
IF UNDER 1 YEAR: Months: 0 Days: 12
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Forman

10b. KIND OF BUSINESS OR INDUSTRY: Horse Race Stable

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Angelo Fratianni

14. MOTHER'S MAIDEN NAME: Angeline Robucci

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-30-2867

17. INFORMANT: Mr. Angelo Fratianni — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
(b): Stokes-Adams Syndrome — Undetermined
DUE TO
(c): Myocardial fibrosis — Undetermined

4222

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 8, 1957, to Aug 1, 1957, that I last saw the deceased alive on Aug 1, 1957, and that death occurred at 9:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: L. L. Packer Jr. M.D. — ADDRESS (Street, city or town, state): 145 W. Washington — DATE SIGNED: 8/2/57

PHYSICIAN'S NAME (Type): L. L. Packer Jr. — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/5/1957

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — R. Franklin Royer — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: Aug 3, 1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08998 08924

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Enroute to Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Louisiana — b. COUNTY: Orleans
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Orleans 56 x-3
d. STREET ADDRESS: 2010 Palmer Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gary — Middle: Eldridge — Last: Gillis
4. DATE OF DEATH: Month: August — Day: 30 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 10, 1902
9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (State or foreign country): Poydras Plantation La.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Gary Gillis
14. MOTHER'S MAIDEN NAME: Stella Taylor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Mrs. Carlotta Gillis New Orleans La.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arterio-sclerotic coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO (b): acute coronary occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. none
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. none 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none
20f. (City or town) - (County) - (State) -

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: August 31 '57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-4-57
22c. NAME OF CEMETERY OR CREMATORY: Metairie Cemetery
22d. LOCATION (City, town, or county) (State): New Orleans La.
23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Scott F. Minnich & Son Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: Sept. 3. 1957
24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08908

CERTIFICATE OF DEATH

08925

Reg. Dist. No. 302

1

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Clearspring
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Peter S — Middle: Brewer — Last: Gsell

4. DATE OF DEATH: Month: 8 — Day: 12 — Year: 19 57

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 11, 1877

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: farmer

11. BIRTHPLACE (State or foreign country): Franklin Co. Penna.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Andrew Gsell

14. MOTHER'S MAIDEN NAME: Mary Brewer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: P.J. Braungard — Address: 332 S. Pot. St., Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Carcinomatosis, generalized	unknown
DUE TO (b)	Carcinoma of the rectum	unknown
DUE TO (c)		

154X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 20, 19 57, to August 12, 19 57, that I last saw the deceased alive on August 12, 19 57, and that death occurred at 10:18 am, from the causes and on the date stated above.

ACTUAL SIGNATURE: Archie Robert Cohen M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): Archie Robert Cohen, M.D. — Clear Spring, Maryland — 8/12/57

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 8-14-57

22c. NAME OF CEMETERY OR CREMATORY: Mennonite Ch. Cemetery

22d. LOCATION (City, town, or county) (State): Clearspring, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Clark — ADDRESS: Clearspring, Md.

24a. REC'D BY REGISTRAR DATE: Aug 16 1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08910

CERTIFICATE OF DEATH

08926

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 247 Summit Ave.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1 247 Summit Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Worth Middle: Lost: Harne

4. DATE OF DEATH: Month: 8 Day: 9 Year: 19 57

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 3, 1866

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: Danzer Metal Wks

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Harne

14. MOTHER'S MAIDEN NAME: Mary Meredith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 217-09-9971

17. INFORMANT: Mrs. Charles Kitzmiller Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yr

420.0

DUE TO (b): Generalised Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 57, 19___, to Aug 9, 1957, that I last saw the deceased alive on Aug 7, 1957, and that death occurred at 10:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert V. Campbell M.D. ADDRESS (Street, city or town, state): 145 W Washington St DATE SIGNED: 8/10/57

PHYSICIAN'S NAME (Type): Robert V. Campbell Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 8-12-57

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Fred W. Kraiss Hagerstown, Md.

24a. REC'D BY REGISTRAR: Aug. 13. 1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08947 **CERTIFICATE OF DEATH** 08927

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hagerstown
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hagerstown RD6 (State Line)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rural - Hagerstown
d. STREET ADDRESS Hagerstown RD6 (State Line)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ELEANOR Middle ELIZABETH Last HARTLE
4. DATE OF DEATH Month August Day 20 Year 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH February 23, 1877
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) State Line
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Daniel Barnhart
14. MOTHER'S MAIDEN NAME Ruth Ann Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Stanley W. Hartle Address Hag. RD6 (State Line)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR Collapse — INTERVAL BETWEEN ONSET AND DEATH: min

443X

DUE TO (b) HYPERTENSIVE Cardiovascular Dis — hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) ARTERIOSCLEROSIS — yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-4-57, 19__, to 9-4-57, 19__, that I last saw the deceased alive on 9-4-57, 19__, and that death occurred at 10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Louis G Graff M.D. ADDRESS (Street, city or town, state) 119 E. Antietam St. DATE SIGNED

PHYSICIAN'S NAME (Type) Louis G. GRAFF M.D. Hagerstown. 8-20-57

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8/23/57
22c. NAME OF CEMETERY OR CREMATORY Beautiful View
22d. LOCATION (City, town, or county) (State) Washington Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE A.E. Minnich ADDRESS Greencastle, Penna.
24a. REC'D BY REGISTRAR DATE Aug 20 1957
24b. REGISTRAR'S SIGNATURE Charles H Boevers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I 119 E. Antietam Dr. Graff 00

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08948

08928

Reg. Dist. No. 321

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 82 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 14 Conococheague St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport Md. x 2
d. STREET ADDRESS: 14 Conococheague St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertie; Middle: IMO; Last: Hawken

4. DATE OF DEATH: Month: Aug.; Day: 31; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 1 1874

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months: 8; Days: 30
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Williamsport Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: William Oscar Bowser

14. MOTHER'S MAIDEN NAME: Hannah Ardinger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Richard G. Hawken
Address: 14 Conococheague Williamsport Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Uteri Cachexia — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO
174 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-28-57, 19__ to 8-31-57, 19__, that I last saw the deceased alive on 8-31-57, and that death occurred at 4:30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph Eyerly M.D. — ADDRESS (Street, city or town, State): Williamsport Md. — DATE SIGNED: 9/3/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 3-57

22c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

22d. LOCATION (City, town, or county) (State): Williamsport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Albert Leaf — ADDRESS: Williamsport Md

24a. REC'D BY REGISTRAR DATE: Sept 3-57

24b. REGISTRAR'S SIGNATURE: E Lee McElroy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08929

~~08~~911

CERTIFICATE OF DEATH

Reg. Dist. No. 302

M C 81 I 0 2 1

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 Hrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Wash. County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Smithsburg R # 2
d. STREET ADDRESS: 1 Edgemont Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First DORIS; Middle FAY; Last HORST

4. DATE OF DEATH: Month Aug; Day 28; Year 1957

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Aug 28 1957
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours 10; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: ɾnfant
11. BIRTHPLACE (State or foreign country): Hagerstown Wash. Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David K. Horst
14. MOTHER'S MAIDEN NAME: Arlene Whitmore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ——
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: David K. Horst Smithsburg R#3 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity and pulmonary atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 10 hr.
762.5
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 28, 1957, to Aug. 28, 1957, that I last saw the deceased alive on Aug. 28, 1957, and that death occurred at 12:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: B. B. Kneisley M.D.
ADDRESS (Street, city or town, state): 148 West Washington Street
DATE SIGNED: 8/28/57
PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.
Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/29/57
22c. NAME OF CEMETERY OR CREMATORY: Weltys Cemetery near G
22d. LOCATION (City, town, or county) (State): reensburg Wash Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR: Aug. 30, 1957
24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

2081385XV2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08949 — 08930 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Knoxville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rural R # 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Knoxville
d. STREET ADDRESS: Rural R # 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Jospeh — Middle: Thomas — Last: Johnson
4. DATE OF DEATH: Month: Aug. — Day: 2 — Year: 19 57
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Aug. 15,1884
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm laborer
10b. KIND OF BUSINESS OR INDUSTRY: Apple orchards
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Johnson
14. MOTHER'S MAIDEN NAME: Caroline V.Hall
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): World 1 — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-16-1756
17. INFORMANT — Address: Wm.Douglas Johnson,Baltimore,Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gun Shot wound (12 gauge shot gun) into chest and region of heart -hemorrhage and shock
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot self in lt chest with 12 gauge shot gun
20c. TIME OF INJURY — Hour: 10:00 m xx — Month, Day, Year: Aug. 2 1957
20d. INJURY OCCURRED — While at work [ ] Not while at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): at home
20f. (City or town) Knoxville Rural — (County) Wash. — (State) Md

21. I certify that I took charge of the remains described above, held an Autapsy [ ], Inspectian [X], Inquiry [ ], and find that death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Hamicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: Aug. 2 '57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-6-1957
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cem'y.
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: B. Lee Feute — ADDRESS: Brunswick, Maryland
24a. REC'D BY REGISTRAR — DATE: AUG 7 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08912

CERTIFICATE OF DEATH

08931

Reg. Dist. No. 302J

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 2DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 MAPLEVILLE
d. STREET ADDRESS: BOONSBORO MARYLAND ROUTE 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ 2

3. NAME OF DECEASED (Type or print): First JAMES — Middle RUSH — Last KEADLE

4. DATE OF DEATH: Month AUGUST — Day 10 — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 21 1871

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER

10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM

11. BIRTHPLACE (State or foreign country): NR. BOONSBORO WASH.CO.MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOHN E. KEADLE

14. MOTHER'S MAIDEN NAME: HELEN FORD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: CHARLES K. KEADLE BOONSBORO MD. ROUTE 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

420.1

DUE TO (b): Generalized arteriosclerosis — 5 yrs

Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 7, 1957, to Aug 10, 1957, that I last saw the deceased alive on August 9, 1957, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C.W. LeVan M.D. — ADDRESS (Street, city or town, state): Boonsboro — DATE SIGNED: 8/11/57

PHYSICIAN'S NAME (Type): C. W. LeVan Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: AUG. 12 1957

22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

22d. LOCATION (City, town, or county) (State): BOONSBORO WASH.CO.MD.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: East Funeral Home Boonsboro Md.

24a. REC'D BY REGISTRAR: Aug. 14. 1957

24b. REGISTRAR'S SIGNATURE: Thos. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmC219 8-14-57 et

08913

CERTIFICATE OF DEATH

08932 304

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Died inroute to Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Hancock Maryland.
d. STREET ADDRESS: 255 W Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: Howard — Last: Keefer

4. DATE OF DEATH: Month: 8 — Day: 2 — Year: 19 57

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7.20.1905

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days: 13
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trackman B&O.R.R.

10b. KIND OF BUSINESS OR INDUSTRY: B&O R.R.

11. BIRTHPLACE (State or foreign country): Fulton County Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Martin V.B.Keefer

14. MOTHER'S MAIDEN NAME: Sally Keefer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): N (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-05-9268

17. INFORMANT: Mrs Geneva B Keefer — Address: 255 W Main St. Hancock Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mesenteric Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6hrs
DUE TO (b): unknown
DUE TO (c):

466X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 2 19 57 to Aug 2 19 57, that I last saw the deceased alive on Aug 2 19 57, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: D.H.Shaffer M.D. — ADDRESS (Street, city or town, state): Hancock Md. — DATE SIGNED: 8/3/57

PHYSICIAN'S NAME (Type): D.H.SHAFFER — HANCOCK MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8.6.57

22c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery

22d. LOCATION (City, town, or county) (State): Hancock Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard F Stine — ADDRESS: Hancock Md

24a. RECD BY REGISTRAR DATE: 8/6/57

24b. REGISTRAR'S SIGNATURE: Ruth Keller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08914 09934

CERTIFICATE OF DEATH

Reg. Dist. No. 10 1

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock X2
d. STREET ADDRESS: R D #I 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

3. NAME OF DECEASED (Type or print): First Debra Middle Marie Last Kidwell

4. DATE OF DEATH: Month August Day 23 Year 1957

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June I2, I955
9. AGE (In years last birthday): 2 yrs.
IF UNDER 1 YEAR: Months I Days II
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: Child
11. BIRTHPLACE (State or foreign country): Berkeley Springs, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Leo Kidwell
14. MOTHER'S MAIDEN NAME: Geraldine Decker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT Address: Robert Leo Kidwell, Hancock Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Neuroblastoma, with — INTERVAL BETWEEN ONSET AND DEATH: about 6 Mo.
DUE TO
193X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) generalized metastasis to skull,
DUE TO
(c) long bones & mediastinum

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Anemia severe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/20/57, 19, to 8/23/57, 19, that I last saw the deceased alive on 8/23/57, 19, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. M. Bacon Jr M.D. ADDRESS (Street, city or town, state): 302 N. Potomac St. Hagerstown DATE SIGNED: 9/1/57

PHYSICIAN'S NAME (Type): A. M. Bacon Jr 302 N. Patomac St, Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/25/57
22c. NAME OF CEMETERY OR CREMATORY: Great Cacapon Cem.
22d. LOCATION (City, town, or county) (State): Great Cacapon, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: C E Shaver ADDRESS: PARKS FUNERAL HOME Berkeley Spgs, W. Va.
24. RECD BY REGISTRAR DATE: SEP 16 1957
24b. REGISTRAR'S SIGNATURE: Chas A Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08950 **CERTIFICATE OF DEATH** 08933

Reg. Dist. No. 303

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown, Md.
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Conococheague Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hancock, Maryland R/
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Clifford; Middle: Benjamin; Last: Landers

4. DATE OF DEATH: Month: August; Day: 11; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 6, 1875

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months: 11; Days: 5 IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Cecil County Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Landers

14. MOTHER'S MAIDEN NAME: Mary Mendenall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-03-9455

17. INFORMANT: Address: Mrs. Pearl Caddie Rural 1 Hancock, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arterial Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year

420.0

DUE TO (b): Arterial Sclerosis — 10 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar. 15, 1957 to Aug. 11, 1957, that I last saw the deceased alive on Aug 10, 1957, and that death occurred at 2:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David R Brewer M.D. ADDRESS (Street, city or town, state): Clear Spring Md DATE SIGNED: 8/13/57

PHYSICIAN'S NAME (Type): David R. Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/14/57

22c. NAME OF CEMETERY OR CREMATORY: Catholic Cemetery

22d. LOCATION (City, town, or county) (State): Hancock Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard J Grove ADDRESS: Hancock md

24a. REC'D BY REGISTRAR DATE: Aug 14-57

24b. REGISTRAR'S SIGNATURE: Leroy M Fockler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

RECEIVED

AUG 26 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08915 (08934) Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 17 East Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

3. NAME OF DECEASED (Type or print): First: Claude — Middle: H — Last: Leaman

4. DATE OF DEATH: Month: August — Day: 5 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 8,1875

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Bookbinder

10b. KIND OF BUSINESS OR INDUSTRY: Printing

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John F. Leaman

14. MOTHER'S MAIDEN NAME: Jane Eversfield Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-28-8790

17. INFORMANT: Claude H. Leaman — Address: 17 East Ave. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple fracture ribs — INTERVAL BETWEEN ONSET AND DEATH: 3½ hrs
DUE TO (b): Fracture pelvis — 3½ hrs
Hemorrhage and shock — 3½ hrs
DUE TO (c):

812X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Hit by truck while crossing street

20c. TIME OF INJURY: Hour: 3:10 XXX p. m. — Month, Day, Year: 8-5-1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town): Hagerstown (County): Washington (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-6-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: August 8,1957
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county): Hagerstown (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown, Md.
24a. REC'D BY REGISTRAR: Aug. 7. 1957
24b. REGISTRAR'S SIGNATURE: Wm. G. Monk C-Pres.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08916

08935

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 35 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 822 Woodland Way
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: Cronise — Last: Lease

4. DATE OF DEATH: Month: August — Day: 9 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 21, 1892

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Implement Supply

10b. KIND OF BUSINESS OR INDUSTRY: Farm Machinery

11. BIRTHPLACE (State or foreign country): Frederick, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward C. Lease

14. MOTHER'S MAIDEN NAME: Fannie Cronise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W. #1

16. SOCIAL SECURITY NO.: 214-09-9702

17. INFORMANT: Mrs. Margaret R. Lease — Address: 822 Woodland Way - Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cerebral Hemorrhage
443X
DUE TO (b): Hypertensive cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. None

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: none 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none
20f. (City or town): - (County): - (State): -

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-10-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-11-57
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven
22d. LOCATION (City, town, or county): Hagerstown, Wash (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Norment
ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR: Aug. 12, 1957
24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08917

CERTIFICATE OF DEATH

08936

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 25 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
d. STREET ADDRESS 1921 Mulberry Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Warren Middle Light Last Lettich

4. DATE OF DEATH Month August Day 26 Year 1957

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Sept. 30, 1896
9. AGE (In years last birthday) 60 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker
10b. KIND OF BUSINESS OR INDUSTRY Iron Works
11. BIRTHPLACE (State or foreign country) Lebanon Penn.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Lettich
14. MOTHER'S MAIDEN NAME Emma Light

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ——— (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-09-2137
17. INFORMANT Address Mrs. Ruth E. Lettich Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency & 584X
DUE TO (b) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Acute Cholelithiasis — 5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 26, 1957, to 26 Aug 1957, that I last saw the deceased alive on 26 Aug 1957, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE J. D. Wilson M.D. ADDRESS (Street, city or town, state) 135 N. Potomac St Hagerstown Md. DATE SIGNED 8-27-57

PHYSICIAN'S NAME (Type) J. D. WILSON, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-29-57
22c. NAME OF CEMETERY OR CREMATORY Mt. Annville Cemetery
22d. LOCATION (City, town, or county) (State) Annville Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son Hagerstown Md.
24a. REC'D BY REGISTRAR DATE Aug 29 1957
24b. REGISTRAR'S SIGNATURE Chas H Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08918

CERTIFICATE OF DEATH

08937

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Jackson Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): 03 Hagerstown
d. STREET ADDRESS: 705 Orchard Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LIDA; Middle ELLA; Last LINDSAY

4. DATE OF DEATH: Month August; Day 21; Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 31,1897

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Washington County,Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John D.Higgs

14. MOTHER'S MAIDEN NAME: Florenee V.Ditto

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr.Geo.R.Lindsay 705 Orchard Rd.Hagerstown,Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Vascular hypertension — INTERVAL BETWEEN ONSET AND DEATH: 27 yrs
331X
DUE TO: Acute Cerebral hemorrhage — 80 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): None

20c. TIME OF INJURY Month, Doy, Year; Hour o. m. p. m.: none 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) – (County) – (State) –

21. I certify that I attended the deceased from Oct. 19 32, to Aug. 21 19 57, that I last saw the deceased alive on Aug. 19 19 57, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Robert Wells M.D.
ADDRESS (Street, city or town, state): 115 N. Potomac Street
DATE SIGNED: 8-21-57

PHYSICIAN'S NAME (Type): S. Robert Wells, M.D. — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/23/57
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Rest Haven Funeral Chapel Inc. 1601 Penna.Ave. Hagerstown,Md.

24a. REC'D BY REGISTRAR DATE: Aug.22.1957

24b. REGISTRAR'S SIGNATURE: Chas.H.Bowers

Wm. A. Host & Bro.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removol, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08938

08919

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 58 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1226 Crescent Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1 1226 Crescent Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elsie — Middle: May — Last: Manious

4. DATE OF DEATH: Month: 8 — Day: 22 — Year: 1957

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 19, 1887

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Clearspring, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Wilkes

14. MOTHER'S MAIDEN NAME: Lucy Rockwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Walter Lake — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 min
DUE TO (b): Arteriosclerotic C.V. Disease — 5 yrs
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/6/57, 19____, to 8/22/57, 19____, that I last saw the deceased alive on 8/22/57, 19____, and that death occurred at 4.30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Searl Young M.D. — ADDRESS (Street, city or town, state): Hagerstown, Md. — DATE SIGNED: 8/24/57

PHYSICIAN'S NAME (Type): SEARL YOUNG M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 8-25-57

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill

22d. LOCATION (City, town, or county): Hagerstown (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W. Kraiss — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR: Aug. 26. 1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08920 08939

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 40 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1820 Concord St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nora — Middle Myrtle — Last Marshall

4. DATE OF DEATH: Month August — Day 24 — Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 7, 1902

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b. KIND OF BUSINESS OR INDUSTRY: Diner

11. BIRTHPLACE (State or foreign country): Keedysville Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Churchey

14. MOTHER'S MAIDEN NAME: Irene Kendle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Walter E. Marshall Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Glomerulo Nephritis — INTERVAL BETWEEN ONSET AND DEATH:

592x

DUE TO (b): Diabetes Mellitus — 4 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Hypo Hypertension — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

260x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 23, 19 [illegible] to Aug 24, 19 57, that I last saw the deceased alive on Aug 24, 19 57, and that death occurred at 11:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): 159 W. Washington St. Hag. Md.

DATE SIGNED: 8/26/57

PHYSICIAN'S NAME (Type): Dr. Philip J. Hirshman 159 W. Washington St., Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-30-57

22c. NAME OF CEMETERY OR CREMATORY: Benevola E. U. B.

22d. LOCATION (City, town, or county) (State): Benevola Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son Hag. Md.

24a. REC'D BY REGISTRAR (Date): Aug. 29, 1957

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08940

08951 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): In auto just out of Hagerstown on Cavetown Pike

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 242 S. Mulbery Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EDWARD — Middle: H — Last: MARTIN

4. DATE OF DEATH: Month: August — Day: 1 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Nov.16,1932

9. AGE (In years last birthday): 24 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cabinet Maker

10b. KIND OF BUSINESS OR INDUSTRY: Furniture Mfg.

11. BIRTHPLACE (State or foreign country): Hagerstown,Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wilbur H.Martin

14. MOTHER'S MAIDEN NAME: Carrie E.Reynolds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs.Edward H.Martin — 242 South Mulberry St. Hagerstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Ruptured, healed dissecting aneurysm of ascending aorta — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Rheumatic valvular heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH: none

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY Hour: a. m. / p. m. — Month, Day, Year: none 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town): - (County): - (State): -

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-2-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug.4,1957

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county): Hagerstpwn (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown,Md.

24a. REC'D BY REGISTRAR: Aug.1.1957

24b. REGISTRAR'S SIGNATURE: Chas H Bowers

Wm. A. Hoar V. Pres

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08952

CERTIFICATE OF DEATH

08941
Reg. Dist. No. 304

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock Rural 1
c. LENGTH OF STAY IN 1b: Life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock Rural 1 x2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home

d. STREET ADDRESS: Rural 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Florence — Middle: Laveine — Last: McCusker

4. DATE OF DEATH: Month: 8 — Day: 21 — Year: 19 57

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2.26.1873

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Washnighton Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Barnhart

14. MOTHER'S MAIDEN NAME: Sallie Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None Rx

17. INFORMANT — Address: Raleigh E McCusker Hancock Rural 1.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

450.0

DUE TO (b): Malnutrition — 2 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 19 55, to Aug 22, 19 57, that I last saw the deceased alive on Aug 20, 19 57, and that death occurred at 8 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: H E Tabler MD. M.D. — ADDRESS (Street, city or town, state): Hancock, Md — DATE SIGNED: 8/23/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8.24.57

22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery

22d. LOCATION (City, town, or county) (State): Near Hancock Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard F Stone — ADDRESS: Hancock Md

24a. REC'D BY REGISTRAR — DATE: 8-24

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08942

08921

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 2 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 TILGHMANTON
d. STREET ADDRESS: FAIRPLAY MD. ROUTE 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARVEY — Middle WOODROW — Last MOATS

4. DATE OF DEATH: Month AUGUST — Day 4 — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 6 1878

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: HOME BUILDING

11. BIRTHPLACE (State or foreign country): TILGHMANTON WASH.CO.MD.U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JACOB MOATS

14. MOTHER'S MAIDEN NAME: ANNIE MONGAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 214 09 9952

17. INFORMANT: MRS. FLORENCE MOATS — Address: FAIRPLAY MD. R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-3-57, 19__, to 8-4-57, 19__, that I last saw the deceased alive on 8-3-57, 19__, and that death occurred at 11P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph F. Young M.D. — ADDRESS (Street, city or town, state): Williamsport, Md. — DATE SIGNED: 8/5/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: AUG. 7 1957

22c. NAME OF CEMETERY OR CREMATORY: MANOR CEMETERY NEAR

22d. LOCATION (City, town, or county) (State): TILGHMANTON WASH.CO.MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Bast Funeral Home — ADDRESS: Boonsboro Md.

24a. REC'D BY REGISTRAR: Aug. 7.1957

24b. REGISTRAR'S SIGNATURE: Chas H Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 M 81 I 0 0 1

DR. RALPH F. YOUNG WILLIAMSPORT MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08953

CERTIFICATE OF DEATH

08944

Reg. Dist. No. 305

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
c. LENGTH OF STAY IN 1b: MINUTES
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MAIN ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAGERSTOWN RT 2 x2
d. STREET ADDRESS: ROUTE 40
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JACOB Middle BREWER Last MUMMA

4. DATE OF DEATH: Month 8 Day 14 Year 57 19

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 24, 1887

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FOREMAN

10b. KIND OF BUSINESS OR INDUSTRY: STATE RD. COMM.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT MUMMA

14. MOTHER'S MAIDEN NAME: FRANCES MASTERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-36-3498

17. INFORMANT: MRS. ROBERTA MUMMA Address: HAGERSTOWN RT 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): acute coronary occulsion — INTERVAL BETWEEN ONSET AND DEATH: 1 minute
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 14, 19 57, to Aug 14, 19 57, that I last saw the deceased alive on Aug. 14, 19 57, and that death occurred at 5:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: G.W. Leban M.D. ADDRESS (Street, city or town, state): Boonsboro DATE SIGNED: 5/16/57

PHYSICIAN'S NAME (Type): G. W. Leban M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/17/1957

22c. NAME OF CEMETERY OR CREMATORY: GREEN LAWN

22d. LOCATION (City, town, or county) (State): WILLIAMSPORT WASH CO MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Clark ADDRESS: CLEAR SPRING, MD.

24a. REC'D BY REGISTRAR DATE: Aug 20 1957

24b. REGISTRAR'S SIGNATURE: John H. Bard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08954

08945 304

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Washington — Md — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Big Pool Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Big Pool Md. XO
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: Murray

4. DATE OF DEATH: Month: 8. — Day: 28 — Year: 19 57

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3.20.1892

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months: 5 — Days: 8 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Washington County Md

12. CITIZEN OF WHAT COUNTRY? U.S.A?

13. FATHER'S NAME: Jeremiah Beard

14. MOTHER'S MAIDEN NAME: Margarett Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Jesse B Murray Big Pool Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Bowel Colon — INTERVAL BETWEEN ONSET AND DEATH: Indefinite
153X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1950 to Aug 25, 1957, that I last saw the deceased alive on Aug 22, 1957, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H. E. Table M.D. M.D. — ADDRESS (Street, city or town, state): Hancock Md — DATE SIGNED

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8.31.57

22c. NAME OF CEMETERY OR CREMATORY: Park Head Cemetery

22d. LOCATION (City, town, or county) (State): Near Big Pool Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Howard J Stine Hancock md

24a. RECD BY REGISTRAR DATE: 8/31/57

24b. REGISTRAR'S SIGNATURE: H E Keller

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08922 | 08946 | Reg. Dist. No. 30

1. PLACE OF DEATH
a. COUNTY: Washington | MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. County Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Penna | b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockledge 75x3
d. STREET ADDRESS: 378 Holme Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RONALD | Middle: JAMES | Last: POLIS
4. DATE OF DEATH: Month: August | Day: 11 | Year: 1957 19

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 4 1935
9. AGE (In years last birthday): 21 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: ----
11. BIRTHPLACE (State or foreign country): Phila Penna
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William A. Polis
14. MOTHER'S MAIDEN NAME: Amelia D. Heintz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -----
16. SOCIAL SECURITY NO.:
17. INFORMANT: William A. Polis | Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 833x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Fractured skull ,hemorrhage & shock
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Entangled with another racing car,on speedway
20c. TIME OF INJURY: Hour: 2:30 a.m. p.m. | Month, Day, Year: 8-11 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town): Conocheague | (County): Wash. | (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, (Inspection ☒, (Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Aug. 12 '57
EXAMINER'S NAME (Type): S. Robert Wells, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/14/57
22c. NAME OF CEMETERY OR CREMATORY: Lawn View Cemetery
22d. LOCATION (City, town, or county) (State): Rockledge Montgomery Co Pa.

23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS: Andrew K. Coffman Hagerstown Md
24a. REC'D BY REGISTRAR DATE: AUG 13 1957
24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08923

CERTIFICATE OF DEATH

08947

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 15 Mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 419 Mayfair Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 419 Mayfair Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAZEL — Middle SUSAN — Last PRYOR

4. DATE OF DEATH: Month August — Day 7 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 30 1898

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Department Store

11. BIRTHPLACE (State or foreign country): Garfield Fred Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William F. Lewis

14. MOTHER'S MAIDEN NAME: Mary Forrest

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: 214-09-7992

17. INFORMANT: Robert R. Pryor — Address: 419 Mayfair Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of uterus — Hagerstown Md. — INTERVAL BETWEEN ONSET AND DEATH: 6 months
174X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 15, 19 57 to Aug 7, 19 57 that I last saw the deceased alive on Aug 6, 19 57, and that death occurred at 24 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Harrison M.D. — ADDRESS (Street, city or town, state): 318 N. Potomac ST. — DATE SIGNED: 8-9-57

PHYSICIAN'S NAME (Type): PAUL HARRISON MD — Hagerstown, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/10/57

22c. NAME OF CEMETERY OR CREMATORY: Mt Zion E.U.B. Cemetery

22d. LOCATION (City, town, or county) (State): Myersville Fred. Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Andrew K. Coffman Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: Aug. 12/1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08924

CERTIFICATE OF DEATH

08948

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 9 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 934 Hamilton Blvd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 934 Hamilton Blvd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELL — Middle VIOLET — Last REED

4. DATE OF DEATH: Month August — Day 7 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 26, 1902

9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months 6 Days 11 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elmer A. Shewbridge

14. MOTHER'S MAIDEN NAME: Grace G. Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-09-4131

17. INFORMANT: Mr. Howard W. Reed — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 2 Wks.
153X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of Colon — 1 yr.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 1957, to July 7, 1957, that I last saw the deceased alive on July 7, 1957, and that death occurred at 5:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lloyd A. Hoffman M.D. — ADDRESS (Street, city or town, state): 214 N. Potomac St — DATE SIGNED: 8/7/57

PHYSICIAN'S NAME (Type): Lloyd A. Hoffman — Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/10/1957

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — R. Franklin Rouzer

ADDRESS: Hagerstown, Md

24a. REC'D BY REGISTRAR DATE: Aug 9, 1957

24b. REGISTRAR'S SIGNATURE: Thos. H. Beavers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

C8955 — Reg. Dist. No. 08949

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharpsburg
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 312 West Main Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: W shington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharpsburg
d. STREET ADDRESS: 312 West Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle RANDOLPH — Last REILLY

4. DATE OF DEATH: Month August — Day 24 — Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 3 1865

9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months 10 Days 20 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor Roads

10b. KIND OF BUSINESS OR INDUSTRY: Roads Construction

11. BIRTHPLACE (State or foreign country): Sharpsburg Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: William Reilly

14. MOTHER'S MAIDEN NAME: Mary Ann Rohrer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. Emma Katherine Hoover Sharpsburg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thromboses — INTERVAL BETWEEN ONSET AND DEATH: Instant.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardio-vascular disease — 5 yrs (?)
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 19 57 to Aug. 24, 19 57, that I last saw the deceased alive on Aug. 23, 19 57, and that death occurred at 4 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter H. Shealy, M.D. — ADDRESS (Street, city or town, state): Sharpsburg, Md. — DATE SIGNED: 8/25/57.

PHYSICIAN'S NAME (Type): WALTER H. SHEALY.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 26-57

22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

22d. LOCATION (City, town, or county) (State): Sharpsburg Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Leafer — ADDRESS: Williamsport, Md

24a. REC'D BY REGISTRAR DATE: Aug 26-57

24b. REGISTRAR'S SIGNATURE: E. H. Boyer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08926 **CERTIFICATE OF DEATH** 08950

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 24 Hrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ Clear Spring R # 1
d. STREET ADDRESS: Rockdale
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First DANIEL Middle EYSTER Last ROWE

4. DATE OF DEATH: Month August Day 18 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: April 24 1881

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md. Myersville Fred Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Josiah Rowe

14. MOTHER'S MAIDEN NAME: Rebecca Ambrose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: 219-20-2877

17. INFORMANT: Mrs Barbara A. Rowe Address: Greencastle Pa R # 2 Box 224 % Russell C. Rowe

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Tuberculosis with Cavitation — INTERVAL BETWEEN ONSET AND DEATH: unknown

002X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

260X

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 16, 1957 to August 18, 1957 that I last saw the deceased alive on August 18, 1957 and that death occurred at 10:30a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Archie Robert Cohen M.D.

ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type): Archie Robert Cohen, M.D. Clear Spring, Maryland Aug. 19, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/20/57

22c. NAME OF CEMETERY OR CREMATORY: Church of Bretheren Cem

22d. LOCATION (City, town, or county) (State): Broadfording Wash. Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR Date: Aug 21 1957

24b. REGISTRAR'S SIGNATURE: Grant Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08927

CERTIFICATE OF DEATH

08951

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Antrim 75 x -3
d. STREET ADDRESS: RD3 - Greencastle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle F. Last SHAFFER

4. DATE OF DEATH: Month August Day 29 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 16, 1892
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: General
11. BIRTHPLACE (State or foreign country): Mercersburg, Pa.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Simon Shaffer
14. MOTHER'S MAIDEN NAME: Mary Ellen Miseinger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 205-09-6883
17. INFORMANT: Clyde Shaffer — Address: RD3 Waynesboro, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteria - Sclerotic Heart Dis — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs
DUE TO (b): c Congestive Failure — 3 wks
DUE TO (c): ___

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 27 Aug, 1957, to 29 Aug 1957, that I last saw the deceased alive on 29 Aug, 1957, and that death occurred at 8:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul F. Webster M.D.
ADDRESS (Street, city or town, State): Greencastle, Pa.
DATE SIGNED: 30 Aug 57

PHYSICIAN'S NAME (Type): Paul F. Webster, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/1/57
22c. NAME OF CEMETERY OR CREMATORY: Welsh Run Brethren
22d. LOCATION (City, town, or county) (State): Welsh Run, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: A. E. Minnich
ADDRESS: Greencastle Pa.
24c. RECD BY REGISTRAR DATE: Sept. 3. 1957
24b. REGISTRAR'S SIGNATURE: Edward H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

08928

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18: Replacement 5/29/57 G219-L

CERTIFICATE OF DEATH

Reg. Dist. No. 08952 202

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mercersburg 75x-3
d. STREET ADDRESS: 117 East Seminary St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle BEAR — Last SHANK

4. DATE OF DEATH: Month Aug — Day 19 — Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Jany 16 1905

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Md. Hagerstown Wash. Co

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Martin N. Bear

14. MOTHER'S MAIDEN NAME: Lillie Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 186-09-5206

17. INFORMANT Address: Martin L. Shank 117 E. Seminary Ave

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Retroperitoneal Liposarcoma — Mercersburg Pa. — INTERVAL BETWEEN ONSET AND DEATH: Unknown

198X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/14, 19 57, to 8/19, 19 57, that I last saw the deceased alive on 8/18, 19 57, and that death occurred at 6:40 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John H Hornbaker M.D. — ADDRESS (Street, city or town, state): 154 West Washington St., — DATE SIGNED: 8:19:57

PHYSICIAN'S NAME (Type): John H. Hornbaker, M.D. — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/21/57

22c. NAME OF CEMETERY OR CREMATORY: Church of Brethren Cem.

22d. LOCATION (City, town, or county) (State): Broadfording Wash. Co Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: AUG 20 1957

24b. REGISTRAR'S SIGNATURE: Chas. Beverly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08929 **CERTIFICATE OF DEATH** Reg. Dist. No. 08953 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garlock Conv. Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Penna.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Thomas 75x-3
d. STREET ADDRESS: No Street Address
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Grace — Middle: D. — Last: Shatzer

4. DATE OF DEATH: Month: 8 — Day: 5 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-15-1879

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: 3 — Days: 21
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): St. Thomas, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Diffenderfer

14. MOTHER'S MAIDEN NAME: Larue Shetron

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. C. Melvin Shields, St. Thomas, Pa. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho- pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days
491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Mentally Ill

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year: None 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) — (County) — (State) —

21. I certify that I attended the deceased from March 19, 1957, to August 5, 1957, that I last saw the deceased alive on August 5, 1957, and that death occurred at 10:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Robert Wells M.D.
ADDRESS (Street, city or town, state): 115 N. Potomac Street
DATE SIGNED: 8-7-57

PHYSICIAN'S NAME (Type): S. Robert Wells, M.D. — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-9-1957
22c. NAME OF CEMETERY OR CREMATORY: St. Thomas Cem.
22d. LOCATION (City, town, or county) (State): St. Thomas, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: M. Franklin Royer
ADDRESS: Hagerstown, Maryland
24a. REC'D BY REGISTRAR: Aug. 9. 1957
24b. REGISTRAR'S SIGNATURE: Grant Boward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08930

08954

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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2

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 30 Minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 339 Elizabeth Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Atlee — Middle: Barkdoll — Last: Sheiss

4. DATE OF DEATH: Month: Aug. — Day: 30 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 28, 1910

9. AGE (In years last birthday): 47 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Furniture Assembler

10b. KIND OF BUSINESS OR INDUSTRY: Own

11. BIRTHPLACE (State or foreign country): Ringgold Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Barry G. Sheiss

14. MOTHER'S MAIDEN NAME: Leah Barkdoll

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-01-4055

17. INFORMANT: Ruth Rhines Sheiss, 339 Elizabeth Ave., Address Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gun Shot wound into head - 22 calibre — INTERVAL BETWEEN ONSET AND DEATH:

976X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot self in head with 22 calibre

20c. TIME OF INJURY: Hour 8:30 p. m. — Month, Day, Year: Aug. 30 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Hagerstown (County): Wash (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Aug. 30 '57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/2/57

22c. NAME OF CEMETERY OR CREMATORY: Ringgold

22d. LOCATION (City, town, or county) (State): Ringgold, Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Walter J. Grove, Waynesboro Pa

24a. REC'D BY REGISTRAR DATE: SEP 3 1957

24b. REGISTRAR'S SIGNATURE: Chas Bowers

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08931

08955

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: REAR 399 LIBERTY ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle WILLIAM — Last SMITH

4. DATE OF DEATH: Month AUGUST — Day 13 — Year 19 57

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/31/1910

9. AGE (In years last birthday): 46 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: JANITOR WORK

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: CHARLES E. SMITH

14. MOTHER'S MAIDEN NAME: BESSIE BAKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-09-9635

17. INFORMANT: MR. CECIL SMITH — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1 Acute coronary occlusion
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. None

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: none 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) - (County) - (State) -

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-15-57

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/15/57
22c. NAME OF CEMETERY OR CREMATORY: FAHRNEY CHURCH CEM.
22d. LOCATION (City, town, or county) (State): WASHINGTON COUNTY MD.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. J. Normentt, Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: Aug. 16-1957
24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08932

CERTIFICATE OF DEATH

08956

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Martin Manor Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Security
d. STREET ADDRESS: 1 33 Green Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS Middle HAYS Last SMITH

4. DATE OF DEATH: August 8 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 25, 1876

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months 0 Days 13
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Blacksmith

10b. KIND OF BUSINESS OR INDUSTRY: Panama Canal Zone

11. BIRTHPLACE (State or foreign country): Woodbury, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Henry Smith

14. MOTHER'S MAIDEN NAME: Liza Noonen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-6892

17. INFORMANT: Mrs. Emma J. Smith Address: Security, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
334x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease--2 years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 7, 1957, to August 8, 1957, that I last saw the deceased alive on August 7, 1957, and that death occurred at 1:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. T. Layman M.D. M.D. ADDRESS (Street, city or town, state): 100 Professional Arts. Bldg. DATE SIGNED: 8-9-57

PHYSICIAN'S NAME (Type): William T. Layman, M.D. Hagerstown Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/11/1957

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home R. Franklin Rouzer ADDRESS: Hagerstown, Maryland

24a. REC'D BY REGISTRAR (Date): Aug. 13. 1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and [illegible] should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08925 **CERTIFICATE OF DEATH** 08957

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 13 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 412 Summit Ave

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 412 Summit Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FLORA — Middle ELIZABETH — Last SNOOK

4. DATE OF DEATH: Month August — Day 29 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 25 1886

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Md. Tilghmanton Wash. Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Turner

14. MOTHER'S MAIDEN NAME: Harriett Ridenour

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 214-09-8466

17. INFORMANT: Samuel E. Snook — Address: 412 Summit Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: about 3 yrs.

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 14, 1939, to Aug 29, 1957, that I last saw the deceased alive on 7/5, 1957, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Hornbaker M.D. — ADDRESS (Street, city or town, state): 154 West Washington St., — DATE SIGNED: 8:30:57

PHYSICIAN'S NAME (Type): John H. Hornbaker, M.D. — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/1/57

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. RECEIVED BY REGISTRAR (Date): SEP 2, 1957

24b. REGISTRAR'S SIGNATURE: Chas H. Feaser

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08958

08933

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 242 S. Potomac St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 242 S. Potomac St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Roy Middle: Thomas Last: Staubs

4. DATE OF DEATH: Month: Aug. Day: 29, Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 2, 1880

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): clerk

10b. KIND OF BUSINESS OR INDUSTRY: tavern

11. BIRTHPLACE (State or foreign country): Sharpsburg, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frisby Staubs

14. MOTHER'S MAIDEN NAME: Arrabella Grey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-14-5165

17. INFORMANT: Address: Mrs. Irene G. Mowen, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 years
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/18/52, 19__, to 8/29, 1957, that I last saw the deceased alive on 7/30, 1957, and that death occurred at 11:35 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George Jennings M.D. ADDRESS (Street, city or town, state): 136 W. Washington St. DATE SIGNED: 8/30/57

PHYSICIAN'S NAME (Type): George Jennings, M.D. Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 8-31-57

22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

22d. LOCATION (City, town, or county) (State): Sharpsburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.

24a. RECD BY REGISTRAR DATE: Sept. 3, 1957

24b. REGISTRAR'S SIGNATURE: Ethel H. Beard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08959

08934

CERTIFICATE OF DEATH

Reg. Dist. No. 302

M

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 85 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 36 S. POTOMAC ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 36 S. POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LIZZIE — Middle: — Last: STAUFFER

4. DATE OF DEATH: Month: AUGUST — Day: 3 — Year: 19 57

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/18/1866

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH T. HOFFMAN

14. MOTHER'S MAIDEN NAME: MARY McCAULEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MR. ALVIN P. STAUFFER — Address: HAGERSTOWN MD.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Brain Syndrome — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
DUE TO
334.4
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebral arteriosclerosis
DUE TO
(c): Generalized arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1957, to Aug. 3, 1957, that I last saw the deceased alive on Aug. 2, 1957, and that death occurred at 2 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. S. Stauffer M.D. — ADDRESS (Street, city or town, state): 170 W. Washington St — DATE SIGNED: 8/5/57

PHYSICIAN'S NAME (Type): R. S. Stauffer — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/6/57
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Norment — ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR: Aug. 7. 1957
24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08935 08960

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 16½ Hrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Wash. County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X / Big Spring
d. STREET ADDRESS: / Dam # 5 Rd
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First WALTER — Middle JAMES — Last TIMBERMAN

4. DATE OF DEATH: Month August — Day 27 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 4 1907

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Dupont Co

11. BIRTHPLACE (State or foreign country): York york Co Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Parke Timberman

14. MOTHER'S MAIDEN NAME: Janet woodside

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.# 2

16. SOCIAL SECURITY NO.: 147-03-1187

17. INFORMANT — Address: Mary E. Timberman Big Sprimg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Carcinomatosis	unknown
DUE TO	163X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Reticulum cell sarcoma of the right lung	1 year.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 15, 19 57, to Aug. 27, 19 57, that I last saw the deceased alive on Aug. 26, 19 57, and that death occurred at 12:40 am, from the causes and on the date stated above.

ACTUAL SIGNATURE: Archie Robert Cohen M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED:

PHYSICIAN'S NAME (Type): Archie Robert Cohen, M.D. Clear Spring, Md. Aug. 27, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/31/57
22c. NAME OF CEMETERY OR CREMATORY: Salem Baptist Cemetery
22d. LOCATION (City, town, or county) (State): Salem, Salem Co N. Jersey

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR: Aug. 29, 1957
24b. REGISTRAR'S SIGNATURE: Ethel H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08936

CERTIFICATE OF DEATH

08961

Reg. Dist. No. 302

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland
c. LENGTH OF STAY IN 1b: 45yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland 03
d. STREET ADDRESS: 54 Bloom Alley
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Theodore — Middle: (no) — Last: Timbers

4. DATE OF DEATH: Month: Aug — Day: 8 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 16 1905

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janiter

10b. KIND OF BUSINESS OR INDUSTRY: Private family

11. BIRTHPLACE (State or foreign country): Lovettsville Va.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Joseph Timbers

14. MOTHER'S MAIDEN NAME: Lea Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Gertrude William — Address: 140 W Bethel St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Epithelial carcinoma esophagus — INTERVAL BETWEEN ONSET AND DEATH: 3 months (history)
150x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 028. Lues, late latent

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 4, 1957, to August 8, 1957, that I last saw the deceased alive on August 7, 1957, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. D. Layman M.D. — M.D. — ADDRESS (Street, city or town, state): 100 Professional Arts Bldg. — DATE SIGNED: 8-9-57

PHYSICIAN'S NAME (Type): William T. Layman, M.D. — Hagerstown — Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 10 1957
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John R Watson Jr. Hagerstown Md.

24a. REC'D BY REGISTRAR — DATE: Aug. 10. 1957

24b. REGISTRAR'S SIGNATURE: Elsie H. Beavers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08937 — 08962 — Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Williamsport Md RFD 1
d. STREET ADDRESS: / Pinesburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mammie — Middle: Mae — Last: Timmons

4. DATE OF DEATH: Month: Aug. — Day: 30 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 18, 1935

9. AGE (In years last birthday): 21 yrs. — IF UNDER 1 YEAR: Months: 8 Days: 12 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Grocery Store

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Dennis Grams

14. MOTHER'S MAIDEN NAME: Mrs. Mammie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-30-6153

17. INFORMANT: Mr. Leroy D Timmons — Address: Williamsport Md RFD1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fractured(open) rt. tibia — INTERVAL BETWEEN ONSET AND DEATH: 14 days

825X

DUE TO (b): Fractured ribs — 14 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Pulmonary emboli (acute)

Delayed hemorrhage into spleen

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident

20c. TIME OF INJURY: Hour: 10:30 ~~XX~~ a.m. — Month, Day, Year: Aug. 16 '57

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town): Hagerstown — (County): Wash — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): S. Robert Wells, M.D. — Aug. 31'57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Sept. 1-57 — 22c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery — 22d. LOCATION (City, town, or county) (State): Williamsport Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Albert Leof — ADDRESS: Williamsport, Md — 24a. REC'D BY REGISTRAR: Aug. 31. 1957 — 24b. REGISTRAR'S SIGNATURE: Ethel H Bowers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08938 **CERTIFICATE OF DEATH** 08963

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 03
d. STREET ADDRESS: 303 Bryan Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET — Middle CAROLINE — Last WARNER

4. DATE OF DEATH: Month Agust — Day 24 — Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 27 1895
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Hagerstown Wash. Co Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Klipp
14. MOTHER'S MAIDEN NAME: Gertrude Angle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Harry B. Warner Sr — Address: 303 Bryan Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — Hagerstown Md. Co/077
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of Recto-Sigmoid
DUE TO
154X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 27 1957, to Aug 24 1957, that I last saw the deceased alive on Aug 24 1957, and that death occurred at 11:12 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert P. Conrad M.D. — ADDRESS (Street, city or town, state): Hagerstown, Md — DATE SIGNED: 8-26-57

PHYSICIAN'S NAME (Type): Robert P. Conrad — 137 W. Washington

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/27/57
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: Aug. 28. 1957
24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08939 08964

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 10 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ BEAVER CREEK RURAL(CRESHEIM)
d. STREET ADDRESS: HAGERSTOWN MARYLAND ROUTE 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MAUDE Middle ECCARD Last WEAGLY

4. DATE OF DEATH: Month AUGUST Day 16 Year 19 57

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUGUST 8 1886
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): BEAVER CREEK WASH.CO.MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: NATHAN C.ECCARD
14. MOTHER'S MAIDEN NAME: CHARLOTTE R.GAVER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: ROY C.F.WEAGLY HAGERSTOWN MD.ROUTE 1.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Arteriosclerotic heart disease	
DUE TO (b)	with Coronary Insufficiency	2-3 yrs
DUE TO (c)		

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Chronic interstitial cystitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 15, 19 57 to Aug 16, 19 57 that I last saw the deceased alive on Aug 16, 19 57 and that death occurred at 10 32 A.M. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. DiTto III M.D. ADDRESS (Street, city or town, state): 2124 W. Washington St. DATE SIGNED: 8/16/57

PHYSICIAN'S NAME (Type): Edward W. DiTto III, M.D. Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: AUG.18 1957
22c. NAME OF CEMETERY OR CREMATORY: BEAVER CREEK CEMETERY
22d. LOCATION (City, town, or county) (State): BEAVER CREEK WASH.CO.MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
24a. REC'D BY REGISTRAR DATE: Aug 22 1957
24b. REGISTRAR'S SIGNATURE: Rhea H Downes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08940 **CERTIFICATE OF DEATH** 08965

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 33 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 633 S. POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORMAN Middle EVANS Last WEST SR.

4. DATE OF DEATH: Month AUGUST Day 14 Year 19 57

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/1/1908

9. AGE (In years last birthday): 49 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SHOP SUPT.

10b. KIND OF BUSINESS OR INDUSTRY: CONSRUCTION CO.

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN F. WEST

14. MOTHER'S MAIDEN NAME: RUIE EVANS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-1152

17. INFORMANT: MRS. EVELYN N. WEST Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atherosclerosis of the coronary artery — INTERVAL BETWEEN ONSET AND DEATH: 2 hr.
420.1
DUE TO: with occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 14, 19 57 to Aug. 14, 19 57, that I last saw the deceased alive on Aug. 14, 19 57, and that death occurred at 8:35A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: B B Kneisley M.D. ADDRESS (Street, city or town, state): 148 West Washington St. DATE SIGNED: 8/15/57

PHYSICIAN'S NAME (Type): Dr. B. B. Kneisley Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/16/57

22c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEM.

22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Hormant ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR: Aug. 16 1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

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AUG 19 1957
BUREAU V. S.

R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 ho
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RECTOR: After this certificate has been signed by the attending physician and completely filled in
be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 a
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08941 **CERTIFICATE OF DEATH** Reg. Dist. No. 08966

1. PLACE OF DEATH
a. COUNTY: Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lantz 10 x 1.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First William Middle Josiah Last Wilhide

4. DATE OF DEATH: Month August Day 13 Year 19 57

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 11-6-1903

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry W. Wilhide

14. MOTHER'S MAIDEN NAME: Clara K. Damuth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-36-4852

17. INFORMANT: Mrs. Ruth B. Wilhide Address: Lantz, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized metastic carcinoma. — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.
151X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Primary carcinoma of stomach. — 4 mo.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/15, 19 57, to 8/13, 19 57, that I last saw the deceased alive on 8/13, 19 57, and that death occurred at 11:00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles F. Hess M.D. ADDRESS (Street, city or town, state): Smithsburg, Maryland DATE SIGNED: 8/15/57

PHYSICIAN'S NAME (Type): Charles F. Hess

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-16-57
22c. NAME OF CEMETERY OR CREMATORY: United Brethern Cem.
22d. LOCATION (City, town, or county) (State): Thurmont, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond E. Creager ADDRESS: Thurmont, Maryland

24a. RECD. BY REGISTRAR DATE: AUG 16 19

24b. REGISTRAR'S SIGNATURE: Chas A. Conaway

RECEIVED

AUG 16 1957

BUREAU V. S.